Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Simmie Armstrong, Jr., M.D.
(NPI: 1033102181),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-15-1622

Decision No. CR4254

Date: September 25, 2015

DECISION

The Centers for Medicare & Medicaid Services (CMS), through one of its contractors, Novitas Solutions (Novitas), revoked the Medicare enrollment and billing privileges of Simmie Armstrong, Jr., M.D. (Dr. Armstrong) pursuant to 42 C.F.R. § 424.535(a)(8)[1] effective November 6, 2014. On reconsideration, CMS determined Dr. Armstrong did not dispute that he submitted Medicare claims for payment for services he did not render to specific individuals on the dates of service, and he did not dispute that individuals identified in the claims were, in fact, deceased at the alleged time of service. Dr. Armstrong then requested a hearing. CMS now moves for summary judgment, which Dr. Armstrong opposes.

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[1] CMS substantially amended 42 C.F.R. § 424.535(a)(8) effective February 3, 2015. *See* 79 Fed. Reg. 72,500 (Dec. 5, 2014). However, in this case I will apply the 2014 version of 42 C.F.R. § 424.535(a)(8) because the text reflected in that regulation was in effect throughout all of the events in this case (i.e., the dates of Petitioner's claimed services through CMS's revocation of Petitioner's billing privileges).

For the reasons set forth below, I find that there is no genuine dispute of material fact and that CMS is entitled to judgment affirming the revocation of Petitioner's Medicare billing privileges. Accordingly, I grant summary judgment in favor of CMS.

I. Case Background and Procedural History

Dr. Armstrong is a physician in Arkansas. He participated in the Medicare program as a supplier of services.[2] In a March 6, 2014 letter, a CMS administrative contractor, AdvanceMed, informed Dr. Armstrong that he may have violated 42 C.F.R. § 424.535(a)(8) based on filing claims for services provided to deceased beneficiaries. CMS Exhibit (Ex.) 13; CMS Ex. 14 ¶ 8. Dr. Armstrong sent AdvanceMed a claim log regarding the billing for the deceased beneficiaries, but did not provide an explanation. CMS Ex. 13; CMS Ex. 14 ¶ 8. By letter dated October 7, 2014, Novitas notified Dr. Armstrong that it was revoking his Medicare enrollment and billing privileges pursuant to 42 C.F.R. § 424.535(a)(8) because "data analysis" showed 2,063 instances where Dr. Armstrong submitted Medicare claims for home health services using Healthcare Common Procedure Coding System (HCPCS) Code G0181 when the identified beneficiary was not in a covered home health period.[3] Novitas also determined that Dr. Armstrong billed Medicare 215 times for services provided to 62 beneficiaries who were deceased at the time of service. Novitas' initial determination stated that it was revoking Dr. Armstrong's billing privileges, effective November 6, 2014, which was 30 days after the date of the letter. Novitas also imposed against Dr. Armstrong a three-year bar on reenrollment in the Medicare program. CMS Ex. 11.

On October 20, 2014, Dr. Armstrong submitted to Novitas a corrective action plan (CAP) and request for reconsideration. In his submission, Dr. Armstrong listed Novitas' conclusions from its initial determination along with his "subsequent reasons for agreement/disagreement of findings." CMS Ex. 9 at 1. Dr. Armstrong provided information about his electronic medical records and billing system, and explained the errors related to the home health services claims. Under the subheading "Many billing errors were created from Billing on Deceased Individuals," Dr. Armstrong wrote that "[a]fter review of such many errors were created from individuals with duplicate/similar names." CMS Ex. 9 at 4. On December 19, 2014, counsel retained by Dr. Armstrong filed a supplemental reconsideration request and CAP. CMS Ex. 5. The supplemental reconsideration request acknowledged that there were two separate allegations that led to the revocation (i.e., billing for beneficiaries not in a covered home health period and billing for services provided to deceased beneficiaries); however, the supplemental

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[2] A "supplier" is "a physician or other practitioner, or an entity other than a provider, that furnishes health care services under Medicare." 42 C.F.R. § 400.202.

[3] HCPCS Code G0181 is a billing code used for the physician supervision of a patient receiving Medicare-covered services provided by a participating home health agency.

reconsideration request only disputed the impropriety of the claims for home health services. *See* CMS Ex. 5 at 1, 3-4.

On February 24, 2015, CMS's Center for Program Integrity issued a reconsidered determination. CMS noted that a request for reconsideration must state the issues and facts the supplier disagrees with, and the reasons for that disagreement. CMS Ex. 1 at 2. CMS then found that "the submitted reconsideration does not appear to dispute CMS' findings; on the contrary, it appears that [Dr. Armstrong] has accepted CMS' findings." CMS Ex. 1 at 2. CMS continued:

> Further, the fact of billing for deceased beneficiaries is not much discussed in the reconsideration, when it is really the billing for deceased beneficiaries that drives this reconsideration determination. After all, the aberrant home health billing, though unquestionably problematic, is not objectively impossible, and therefore, standing alone, might not have been considered "abuse of billing privileges" within the narrow context of the regulation. In contrast, billing for deceased beneficiaries fits perfectly within one of the expressed instances described as "abuse of billing privileges" by the regulation. As the key fits the lock, [Dr. Armstrong] has fallen neatly and perfectly within the ambit of 42 C.F.R. § 424.535(a)(8); he has provided the textbook case for the very billing practices that 42 C.F.R. § 424.535(a)(8) seeks to account for.

CMS Ex. 1 at 2. CMS "commended" Dr. Armstrong on creating a compliance program as part of his CAP, but took no further action regarding the CAP. Accordingly, CMS upheld the revocation. CMS Ex. 1 at 2.

By letter dated March 12, 2015, Petitioner requested a hearing before an administrative law judge (ALJ) to challenge the reconsidered determination. On March 23, 2015, I issued an Acknowledgment and Pre-hearing Order (Pre-hearing Order), which established general procedures for record development in this case and permitted the parties to file for summary judgment, if appropriate. *See* Pre-hearing Order ¶ 4. CMS timely filed a motion for summary judgment with a supporting brief (CMS Br.) along with 17 proposed exhibits (CMS Exs. 1-17). Petitioner filed an opposition to CMS's motion for summary judgment as well as a supporting brief (P. Br.) and 18 proposed exhibits (P. Exs. 1-18).

In the absence of any objections, I admit CMS Exs. 1-17 and P. Exs. 1-18 into the record for consideration.

II. Issues

This case presents two issues:

1. Whether CMS is entitled to summary judgment; and

2. Whether CMS was authorized to revoke Petitioner's Medicare billing privileges pursuant to 42 C.F.R. § 424.535(a)(8).

III. Jurisdiction

I have jurisdiction to decide the issue in this case. 42 C.F.R. §§ 498.3(b)(17), 498.5(l)(2); *see also* 42 U.S.C. § 1395cc(j)(8).

IV. Findings of Fact, Conclusions of Law, and Analysis

The Social Security Act (Act) authorizes the Secretary of Health and Human Services (Secretary) to establish by regulation procedures for enrolling providers and suppliers in the Medicare program. 42 U.S.C. § 1395cc(j)(1)(A). The Secretary has promulgated enrollment regulations in 42 C.F.R. Part 424, Subpart P. *See* 42 C.F.R. § 424.500 *et seq*. The regulations provide CMS with the authority to revoke the billing privileges of an enrolled provider or supplier if CMS determines that certain circumstances exist. *Id.* § 424.535(a). Relevant to this case, CMS may revoke a provider's or supplier's billing privileges if:

> The provider or supplier submits a claim or claims for services that could not have been furnished to a specific individual on the date of service. These instances include but are not limited to situations where the beneficiary is deceased, the directing physician or beneficiary is not in the State or country when services were furnished, or when the equipment necessary for testing is not present where the testing is said to have occurred.

Id. § 424.535(a)(8). When CMS revokes a provider's or supplier's billing privileges, any provider agreement in effect at the time of revocation is terminated. *Id.* § 424.535(b). In addition, after revocation CMS must impose a bar on re-enrollment for a minimum of one year, but no more than three years. *Id.* § 424.535(c).

A provider or supplier may request reconsideration of the initial determination to revoke his or her billing privileges. 42 C.F.R. §§ 498.5(*l*)(1), 498.22(a). If dissatisfied with the reconsidered determination, the supplier may request a hearing before an ALJ. *Id.* § 498.5(*l*)(2). When appropriate, ALJs may decide a case arising under 42 C.F.R. pt. 498

by summary judgment. *See* Civil Remedies Division Procedures § 19(a); *Livingston Care Ctr. v. U.S. Dep't of Health & Human Servs.*, 388 F.3d 168, 172 (6th Cir. 2004) (citing *Crestview Parke Care Ctr. v. Thomson*, 373 F.3d 743 (6th Cir. 2004)). Summary judgment is appropriate and an in-person hearing is not required if the record shows that there is no genuine dispute of any material fact and the moving party is entitled to judgment as a matter of law. *Senior Rehab. & Skilled Nursing Ctr.*, DAB No. 2300, at 3 (2010) (citations omitted). To determine whether there are genuine issues of material fact for an in-person hearing, the ALJ must view the evidence in the light most favorable to the non-moving party, drawing all reasonable inferences in that party's favor. *Id.* (citation omitted).

1. Summary judgment is appropriate.

There is no genuine dispute of any material fact in this case. CMS presented evidence showing that Petitioner submitted claims for services that could not have been provided to a specific individual on the date of service. CMS Ex. 12 at 2-4; CMS Ex. 14 at ¶¶ 7-8; *see also* CMS Ex. 13. Petitioner compounded this by producing evidence that shows he did not, in fact, provide the services to individual beneficiaries named in certain claims that he submitted. *See, e.g.*, P. Ex. 1 (providing medical treatment records of Dr. Armstrong for an individual with the initials MBN and birthdate of August 9, 1957, but submitting a Medicare claim for an individual with the initials MFB and birthdate of October 29, 1920). Petitioner argues that he provided the service that he claimed, just not to individual identified in the claim. However, the plain language of the regulation does not carve out an exception to revocation for improperly identified beneficiaries. Instead, it authorizes CMS to revoke billing privileges if a supplier submits claims for services that could not have been rendered "to *a specific individual* on the date of service." *See* 42 C.F.R. § 424.535(a)(8) (emphasis added). Any evidence or factual inferences that may be drawn showing that Dr. Armstrong performed the services listed on the claims he submitted to an individual not identified on the claim do not impact the result here. Ultimately, Petitioner has not submitted evidence that detracts from CMS's evidence or raises any genuine dispute of material fact. Thus, this case turns on a matter of law. Summary judgment is appropriate.

For purposes of summary judgment, I draw all inferences in favor of Dr. Armstrong. Even though not material to the outcome, I accept as true, solely for purposes of summary judgment, that Dr. Armstrong performed all of the services listed in the claims he submitted to Medicare for payment. I also accept that Dr. Armstrong did not intend to defraud Medicare and that the improper claims were the result of clerical errors.

2. Dr. Armstrong submitted Medicare payment claims for services that could not have been and were not furnished to a specific individual on the date of service listed in the claim.

CMS has presented the results of an investigation that show Dr. Armstrong submitted Medicare claims for services that could not have been provided to the beneficiaries identified in the claims because the beneficiaries were deceased on the dates of the claimed services. CMS Ex. 12 at 2-4; CMS Ex. 14 at ¶¶ 7-8; *see also* CMS Ex. 13. In response, Dr. Armstrong does not directly dispute that he or his billing agent submitted the claims in question. However, Dr. Armstrong argues that the billing errors were the result of a feature of the billing system used by his office, and that the services described in the claims at issue were in fact rendered to living Medicare beneficiaries with names similar to those of the beneficiaries identified in the claims. P. Br. at 9-12.

The evidence before me shows that Dr. Armstrong submitted at least 77 claims for services that were performed after the beneficiary identified on the claim had died. CMS Ex. 12 at 2-4. The investigation report provides only five deceased beneficiaries as examples of Dr. Armstrong's improper billing, which is why the claim number in the evidence before me is substantially less than what was originally identified in the initial determination. *See* CMS Ex. 11. For all five of the beneficiaries identified in the investigation report, Petitioner submitted claims for services rendered between one month and up to a year after the specific beneficiary's death. CMS Ex. 12 at 2-4.

Ultimately, Petitioner's evidence does not create a genuine dispute about whether he or his billing agent submitted the claims at issue to Medicare, or about whether those claims identified deceased beneficiaries as receiving treatment. Regardless of whether Petitioner provided the claimed services to living individuals — which I accept as true for purposes of summary judgment — the claims he submitted to Medicare identified individuals who did not actually receive the services listed. *See, e.g.*, P. Ex. 1 at 10-11. Therefore, Petitioner has not come forward with evidence to refute CMS's evidence that shows he submitted claims for services that could not have been provided to a specific individual on the date of service.

Dr. Armstrong broadly disputes CMS's evidence that the beneficiaries identified in the Medicare claims were deceased at the time of service, although he offers no evidence demonstrating the contrary to be true regarding the specific beneficiaries identified in the investigation report. *See* P. Br. at 9 n.2, 13. As a preliminary matter, however, Dr. Armstrong's general questioning of whether certain beneficiaries are in fact deceased does little to advance his cause. The regulatory language offers a deceased beneficiary merely as an example of when a service could not be provided to that specific individual. *See* 42 C.F.R. § 424.535(a)(8). The operative language requires that Dr. Armstrong could not have provided services to a specific individual at the time of service. *Id.* Petitioner conceded that to be true and even introduced evidence showing that he did not

provide services to a specific individual identified in the claim he submitted to Medicare. P. Br. at 9-12; P. Exs. 1-12. In essence, Petitioner has removed all doubt as to whether he could have performed the services to a specific individual because his evidence confirms that he did not do so. Moreover, CMS presented evidence of the deaths of certain beneficiaries through a chart prepared during an investigation into Dr. Armstrong's billing practices. *See* CMS Ex. 12. The chart is part of an investigative record, and bears sufficient indicia of reliability. It is certainly true that such evidence could be defeated by Petitioner's own evidence that the beneficiaries identified in the chart were not actually deceased at the time of service. However, Dr. Armstrong has not presented any such evidence. Indeed, Dr. Armstrong did not dispute during the reconsideration level of review that the beneficiaries were deceased, and, even at this level of review, he simply mentions this issue in a footnote, which is hardly sufficient to raise a genuine dispute of fact.[4]

The undisputed evidence presented here is sufficient to establish a prima facie case that the beneficiaries identified in the claims at issue were deceased at the time of the service. At the very least, Petitioner concedes (and even produces evidence) that he did not provide services to the specific individual identified in the claims he submitted to Medicare for payment. Petitioner has offered no evidence to raise a genuine dispute that the beneficiaries identified in the investigation report were alive at the time of service and that he provided treatment to them. A mere denial or unsupported disagreement with certain evidence, which is all Petitioner offers in response to CMS's evidence, is not sufficient to prevent summary judgment. *Senior Rehab.*, DAB No. 2300, at 3.

3. CMS was authorized to revoke Dr. Armstrong's Medicare billing privileges pursuant to 42 C.F.R. § 424.535(a)(8).

Once CMS determined that Dr. Armstrong submitted a claim or claims that could not have been furnished to a specific individual on the dates of service, it was then authorized to revoke Dr. Armstrong's Medicare billing privileges. 42 C.F.R. § 424.535(a)(8). Here, there are at least 77 instances where Dr. Armstrong submitted a claim for a service that could not have been, and, in fact, were not furnished to a specific individual on the date of service. CMS Ex. 12 at 2-4.

Dr. Armstrong's argues that he provided the services claimed to living beneficiaries with names similar to those beneficiaries identified in the claims at issue, but that fact does not

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[4] Dr. Armstrong's failure to raise this issue at the reconsideration level probably precludes Dr. Armstrong from asserting it as a new issue before me. *See* 42 C.F.R. § 498.56(a)(2); 72 Fed. Reg. 9479, 9486 (Mar. 2, 2007) ("Accordingly, we propose to revise § 498.56 and § 498.86 to prohibit providers and suppliers from submitting new provider enrollment issues or evidence at the ALJ and DAB levels of review.).

undermine CMS's authority to revoke Petitioner's billing privileges. I have previously addressed and rejected this argument in a similar case:

> Petitioner's argument overlooks that the regulation authorizing revocation requires that the improper claim be for services that Petitioner could not have provided to "a *specific* individual," not just "an individual." 42 C.F.R. § 424.535(a)(8) (emphasis added). Contrary to Petitioner's argument, the regulation requires specificity with reference to whom the services were allegedly provided, not a generic identification of any individual. The specific individual identified in a claim must be the specific individual who received the services claimed, otherwise the claim is for services that could not have been provided to "a specific individual," and revocation is permissible. *Id.*

Louis J. Gaefke, D.P.M., DAB CR2785, at 9 (2013), *aff'd*, DAB No. 2554, at 8 n.7 (2013). The revocation authority in section 424.535(a)(8) hinges on the appropriate identification of a beneficiary in Medicare claims:

> While section 424.535(a)(8) provides that "abuse of billing privileges" involves submitting a claim or claims "that could not have been furnished to a specific individual on the date of service," the purpose of the phrase "to a specific individual" is to cover situations where a practitioner was available and had the necessary equipment to furnish a service, but could not have furnished the service to the *identified beneficiary* given that beneficiary's status or location.

Realhab, Inc., DAB No. 2542, at 16 (2013) (emphasis added). Thus, consistent with my prior decision in *Gaefke* and the conclusion in *Realhab*, I reject Petitioner's argument that providing services to a living beneficiary not identified in the Medicare claims at issue absolves him from the revocation of his Medicare billing privileges for submitting Medicare claims that identified beneficiaries who could not have received those services at the time.

Dr. Armstrong also argues that he never intended to defraud the Medicare program through his improper billing, and that the billing errors were cases of mistaken identification. P. Br. at 16-17. However, the operative language of the revocation provision applicable in this case does not require that CMS demonstrate Dr. Armstrong intended to defraud the Medicare program before it may revoke Petitioner's billing privileges. *See* 42 C.F.R. § 424.535(a)(8). It merely requires the existence of improper claims. *Id.*; *see also Louis J. Gaefke, D.P.M.*, DAB No. 2554, at 7 ("The plain language

of the regulation contains no requirement that CMS establish that the supplier acted with fraudulent or dishonest intent."). Therefore, Petitioner's claims that he did not act fraudulently by submitting his improper claims is not sufficient to negate CMS's authority to revoke Petitioner's billing privileges pursuant to 42 C.F.R. § 424.535(a)(8).

4. The alleged improper claims related to Dr. Armstrong's claims for home health services under HCPCS Code G0181 are no longer at issue in this matter.

Both parties present arguments regarding Dr. Armstrong's use of HCPCS Code G0181 without a contemporaneous home health period, and whether those claims provide CMS with the authority to revoke his billing privileges. However, my review is limited to the reconsidered determination. *See* 42 C.F.R. § 498.5(*l*)(2). Here, CMS determined in its reconsidered determination that Dr. Armstrong's submission of claims for services that could not have been provided because the named beneficiaries were deceased at the time of service provided a basis for revocation under 42 C.F.R. § 424.535(a)(8). *See* CMS Ex. 1 at 2 ("[I]t is really the billing for deceased beneficiaries that drives this reconsideration determination."). Indeed, CMS expressly found that Dr. Armstrong's billing under HCPCS Code G0181 was not a basis for revocation, writing that "the aberrant home health billing, though unquestionably problematic, is not objectively impossible, and therefore, standing alone, might not have been considered 'abuse of billing privileges' within the narrow context of the regulation." CMS Ex. 1 at 2.

Accordingly, CMS determined in the reconsidered determination that the basis for revoking Dr. Armstrong's Medicare billing privileges was limited to the instances where he billed for services that could not have been provided to the specific individual named in the claim because that individual was deceased. Dr. Armstrong's use of HCPCS Code G0181 is no longer at issue in this case and no longer supports CMS's authority to revoke Dr. Armstrong's billing privileges.

5. CMS rejected Dr. Armstrong's CAP, and that determination is not reviewable by an ALJ.

Dr. Armstrong argues CMS did not consider his CAP and other remedial efforts to correct his billing errors. He also cites to the results of an Arkansas Medicaid audit as support that his corrective measures were indicative of his lack of fraudulent intent in submitting the improper claims. P. Br. at 15.

CMS did not approve Dr. Armstrong's CAP, and tacitly rejected it in the reconsidered determination. CMS Ex. 1 at 2. I conclude that CMS's determination not to grant or approve the CAP means that CMS rejected it, even though it did not expressly say so. It is well-settled that the Act and the Secretary's implementing regulations do not provide for administrative review of the agency's rejection of a CAP. *See* 42 C.F.R.

§ 405.809(b)(2) ("The refusal of CMS or its contractor to reinstate a provider or supplier's billing privileges based on a corrective action plan is not an initial determination [subject to review]."); *DMS Imaging, Inc.*, DAB No. 2313, at 5 (2010). Finally, as explained above, whether or not Dr. Armstrong's corrective measures support his argument that he did not intend to defraud the Medicare program is not relevant to this case. CMS need not find an intent to defraud before it has the authority to revoke billing privileges under 42 C.F.R. § 424.535(a)(8).

V. Conclusion

For the reasons explained above, I grant summary judgment in favor of CMS. There is no genuine dispute of the material facts and CMS is entitled to judgment affirming the revocation of Dr. Armstrong's billing privileges effective November 6, 2014.

/s/

Scott Anderson
Administrative Law Judge